Mississippi Board of Nursing
713 Pear Orchard Road
Ridgeland, Mississippi 39157
Suite 300
601-957-6300

Date: _____

Recovering Nurse Program Screening Application

Please print your name exactly as it appears on your Mississippi Nursing License

_____

(Last) (First) (Middle)

Other last names: (maiden, previous married)

_____

Home Address: Street: _____ City: _____

State: _____ Zip Code: _____

Phone Number: Home: _____ Cell:

Work: _____ Email Address:

Do you use texting from your cell phone: [ ] Yes [ ] No

Social Security Number: _____ Marital Status: _____

Date of Birth: _____ Best time to reach you: [ ] Morning [ ]

Afternoon [ ] Night [ ] Anytime

Licensing Information

Mississippi License Number's: R _____ P _____

State of Original Licensure: _____ Lic. No.: _____

APRN Certification?: _____

Other States of Licensure:

State: _____ State: _____ State: _____

Lic. No.: _____ Lic. No.: _____ Lic. No.: _____

If there are additional States, please list on back.

Have there ever been any disciplinary action against your license or privilege to practice by a licensure agency in any state, or are charges pending in any state?

Yes [ ] No [ ]

Have you participated in a confidential alternative to discipline program in any state?

Yes No

If yes, please explain, including the state(s) in which the action took place or is pending._____

_____

_____

_____

_____

Have you ever been counseled regarding difficulty with nursing practice?(Examples: documentation errors, tardiness, practicing outside of scope, death of a patient) If so, describe:

_____

_____

_____

_____

Have you ever been convicted of a misdemeanor or felony under any local, state, or federal law, or any charges currently pending? Have you participated in any pre-trial diversion programs or had charges expunged? Yes [ ] No [ ]

If yes, please explain, including the state(s) in which action took place or is place or is pending. Documentation (court orders, charges, etc.) may be required.

_____

_____

_____

_____

Have you ever been terminated or discharged from any impaired nurse/diversion program due to non-compliance with the program: Yes [ ] No [ ]

If yes, explain:

_____

_____

Employment Information

Please describe your present or last professional practice, including place and address of employment, job responsibilities, setting typical work schedule, etc.

Presently Employed [ ] Last Place of Employment [ ]

Facility Name: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Position: _____ Unit/Floor : _____

Hours/Shift: _____ DON/Supervisor: _____

Briefly describe job responsibilities: _____

_____

_____

_____

Have you ever been terminated from employment as a nurse? Yes [ ] No [ ]

If yes, please list facility and reason(s) for termination: _____

_____

_____

_____

_____

Please describe your perception of your clinical performance as a nurse for the past year?

_____

_____

_____

_____

_____

Medical Information

Do you have any diagnosed medical condition(s)? Yes [ ] No [ ]

If yes, please list diagnosis and treating health care provider:

Diagnosis: _____ Practitioner: _____

Diagnosis: _____ Practitioner: _____

Diagnosis: _____ Practitioner: _____

Diagnosis: _____ Practitioner: _____

Please list any Prescription(s) and over-the-counter medications you have been prescribed or taken over the past year for medical conditions:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you suffer from chronic physical pain? Yes [ ] No [ ]

If so, how is your pain managed?

_____

_____

_____

_____

Are your current pain management plans effective? Yes [ ] No [ ] N/A [ ]

Psychiatric Information

Have you ever been under the care of a psychologist, psychiatrists, or therapist presently or at any time in the past? Yes [ ] No [ ] If yes, explain:

_____

_____

_____

_____

Have you been hospitalized in the past 30 days for psychiatric symptoms?
Yes [ ] No [ ]

If yes, briefly explain:

_____

_____

_____

Are you currently taking antidepressant, anti-anxiety, mood stabilizers or antipsychotic medications? Yes [ ] No [ ] If yes, please list all psychiatric medications.

_____ _____

_____ _____

_____ _____

Have you ever felt overwhelmed by problems that interfere with mental and emotional wellbeing? If so, describe:

_____

_____

_____

_____

Chemical Abuse/Dependency

Do you feel you have a problem with Alcohol or Drugs? Yes [ ] No [ ]

Do you have the need for increased amounts of the substance to achieve the desired effect? Yes [ ] No [ ]

Have you experienced any type of withdrawal symptoms or have you taken the substance to relieve or avoid withdrawal symptoms? Yes [ ] No [ ]

Do you presently have work-related problems because of your alcohol/drug use? Yes [ ] No [ ]

Do you have legal problems pending because of your alcohol/drug use? Yes [ ] No [ ]

Do you have family/marital problems because of you alcohol/drug use? Yes [ ] No [ ]

Do you have a family history of addiction to alcohol or drugs? Yes [ ] No [ ]

Have you ever experienced a blackout (memory loss) as a result of your alcohol/drug use? Yes [ ] No [ ]

Have you ever been hospitalized or institutionalized as a direct result of your alcohol/drug use? Yes [ ] No [ ] If Yes, When and Where?

_____

Has your alcohol/drug use affected your ability to be a safe nurse while performing your duties? Yes [ ] No [ ]

Please list below your drug(s) of choice and usage patterns:

Name of Drug	Age of first use	Date of last use	How much/often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Alcohol/Drug Treatment History:

Have you had treatment in the past for alcohol/drug treatment? Yes [ ] No [ ]

If yes, please answer the following:

Date(s) of Treatment:	Where?	Did you Complete?	Type of treatment: (inpatient, outpatient)
_____	_____	_____	_____

_____ _____ _____ _____

_____ _____ _____ _____

Are you presently in treatment for alcohol/drugs? Yes [ ] No [ ]

If yes, where, date of admission, counselor's name, and phone number:

_____

If you are not presently in treatment, are you willing to seek treatment recommendations? Yes [ ] No [ ]

Have you ever attended Alcoholics Anonymous or Narcotics Anonymous Meetings?

Yes [ ] No [ ]

Are you presently clean and sober? Yes [ ] No [ ]

If yes, how long have you been chemically free? _____

Personal Data

Do you presently have health insurance? Yes [ ] No [ ]

If yes, please provide the following:

Name of Insurance Company: _____

Are you presently: Married [ ] Divorced [ ] Separated [ ] Widowed [ ] Single [ ]

Does anyone else in your household use alcohol/drugs other than you?

Yes [ ] No [ ] If yes, who? _____

Do you have children? Yes [ ] No [ ] If yes, how many and what age?

_____

Is your present partner supportive of you seeking treatment? Yes [ ] No [ ]

Please describe your insight into your present problems and why you have allegations against your license or privilege to practice in the state of MS.

_____

_____

_____

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_____

_____

_____Do you agree to cease your nursing practice upon assessment results and follow all treatment recommendations? Yes No:

Do you agree to assume financial responsibility for all assessment and treatment costs incurred as a result of participation in the RNP? Yes No:

I declare and affirm that the statements made in this application are true, complete and correct. I understand that any false or misleading information in, or in connection with this application may lead to exclusion or discharge from the Recovering Nurse Program, if accepted.

Signature: _____ Date:_____

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Recovering Nurse Program FAX:
601- 957-6301 (Address Fax; Attention RNP)

Primary Phone for MS Board of Nursing:
601-957-6300
Website: www.msbn.ms.gov